Complete Summary

GUIDELINE TITLE

Working with the active user.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Working with the active user. New York (NY): New York State Department of Health; 2006 Oct. 20 p. [25 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Substance use

GUIDELINE CATEGORY

Counseling
Management
Prevention

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Physician Assistants
Physicians
Public Health Departments
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To provide guidelines for managing patients who are active substance users with human immunodeficiency virus (HIV)-infection

TARGET POPULATION

Active substance users with human immunodeficiency virus (HIV)-infection

INTERVENTIONS AND PRACTICES CONSIDERED

1. Coordinating multidisciplinary care using the following strategies
    - Colocated services
    - Interagency coordination
    - Case management
    - Referral to drug treatment services
2. Engaging and maintaining the patient in care by building a trusting patient-provider relationship and encouraging patient participation early in the treatment-planning process
3. Assessing treatment readiness
4. Relapse prevention using the following strategies:
    - Asking the patient about the date of last use of substance
    - Careful use of medications
    - Appropriate treatment of pain
    - Careful observation for periods of increased stress
    - Educating patients about risks associated with illicit drug use
    - Motivational interview
    - Promoting safer sex practices
    - Promoting harm-reduction techniques by educating patients about access to clean needles, safe storage and disposal of sharps, safe injection techniques, and overdose prevention

MAJOR OUTCOMES CONSIDERED

- Effectiveness of relapse-prevention strategies and harm-reduction techniques in managing active substance users
- Overdose related mortality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice

experience to develop the final statement. The text is then drafted by one member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Introduction

Clinicians should ensure that substance users are engaged in medical care regardless of whether or not they are actively using drugs.

Table 1

Quick Tips for Working with Substance Users

- Design strategies to keep the patient in care, such as reminder systems and peer support
- Ask the patient about his/her treatment goals
- Express concern for the patient's health and wellness and a willingness to address the patient's health needs
- Establish systems to ensure coordination of care across multiple disciplines
- Assess the patient's readiness to change and tailor appropriate interventions
- Encourage behavior change through the use of brief interventions and motivational interviewing
- Introduce harm-reduction techniques for patients who are not yet able to abstain from substance use

Coordination of Multidisciplinary Care

Clinicians should communicate with providers from multiple disciplines to ensure optimal patient care.

Clinicians should have access to available community resources needed for the comprehensive care and management of human immunodeficiency virus (HIV)-infected substance users.

Interagency Coordination

Clinicians and service providers from other sites should establish systems to ensure coordination of care.

The primary care clinician should help ensure that team members' responsibilities for important elements of the patient's care are clearly assigned.

Key Point:

Programs that frequently provide referrals to each other may benefit from developing written, working interagency agreements.

Case Management

Clinicians should refer substance-using patients for case management to enhance coordination of care when care is provided by multiple disciplines and in multiple settings.

Clinicians should regularly involve case managers in case conferences to discuss medical, psychological, social, and substance use issues that may affect a patient's ability to adhere to care.

Key Point:

Appropriate management of substance use issues should include the use of social work, case management, or mental health services, in conjunction with substance use counselors, when available.

Referral for Drug Treatment Services

Clinicians should collaborate with social work staff and other mental health providers, when available, to determine which treatment programs or substance use services best meet the patient's needs.

Engaging and Maintaining the Patient in Care

Building a Therapeutic Relationship

Clinicians who are uncomfortable or inexperienced with treating substance-using patients should seek guidance from providers with more experience in this area.

Clinicians should tailor interactions with substance-using patients to facilitate a trusting relationship for engaging and retaining patients in care.

Table 2

Patient-Provider Communication as a Collaborative Process

Build trust

- Ask the patient about his/her treatment goals
- Be explicit (both to the patient and to yourself) regarding how you intend to provide treatment for the patient
- Be consistent and respectful
- Meet the patient "where they're at"

Avoid shaming the patient in any way

- Address ongoing drug use or resumption of use in a nonpunitive fashion
- Address substance use in clinical terms and avoid judgmental language that can exacerbate stigma, such as "substance abuse"

Provide positive feedback

- Improved clinical results when applicable
- Adoption of healthful behaviors
- Elimination or reduction of less healthful behaviors

Encouraging Patient Participation

Clinicians should actively engage HIV-infected substance users early in the treatment-planning process.

Assessing Treatment Readiness and Relapse Prevention

Assessing Treatment Readiness

Clinicians should address substance use with active substance users and assess their readiness for substance use treatment at the initial visit and routine monitoring visits.

Relapse Prevention

Clinicians should ask patients who have been abstinent from illicit drug use for less than 1 year about the date of last use at routine monitoring visits.

Key Point:

Stable abstinence depends on relapse prevention and not just detoxification.

Table 3

Reasons for and Strategies to Prevent Relapse

Common Reasons for Relapse:

- Patient not well prepared for the significant and prolonged effort needed to maintain sobriety
- Patient not clear about the specific overall treatment goals
- Patient not properly equipped with strategies (refusal skills, recognition of cues, coping skills) to anticipate and react to high-risk situations

Strategies to Prevent Relapse:

- Careful use of medications to avoid inadvertently treating the patient with medications that could lead to relapse
- Appropriate treatment of pain because untreated pain may be a trigger for relapse
- Careful observation for periods of increased stress

Key Point:

A patient's unwillingness to discuss his/her recovery program with the primary care clinician may be one of the first signs of relapse.

Spectrum of Interventions

Clinicians should offer and support a repertoire of substance use treatment goals, such as abstinence, a reduction in use, or safer use, and should advocate safer sex practices among HIV-infected substance users.

Brief Interventions and Education

Clinicians should educate substance-using patients about the detrimental effects of illicit drug use, alcohol use, and misuse of prescription drugs to help stimulate behavior change.

Clinicians should present information in language that is easily understood by the patient, avoiding medical jargon and ensuring that written materials are tailored to the intended audience.

Motivational Interviewing

Table 4

Key Components of Motivational Interviewing

Component	Involves
Expressing empathy	Understanding and being aware of and sensitive to the feelings, thoughts, and experiences of another. Accomplished through reflective listening.
Supporting self-efficacy	Supporting the patient with the sense that an individual can identify and meet one's needs and goals.
Avoiding argumentation and	Listening to the patient's resistance to change.

Table 4 Key Components of Motivational Interviewing	
Component	**Involves**
rolling with resistance	Working collaboratively with the patient to develop his/her input regarding the treatment plan.
Discovering discrepancies	Helping patients identify discrepancies between their current behavior and desired future behavior.

Promoting Safer Sex Practices

Clinicians should discuss behavioral risk-reduction measures for prevention of sexually transmitted infections, including correct and consistent condom use, on a routine and ongoing basis.

Harm-Reduction Approach

Key Point:

Some patients using multiple substances may diminish or stop using one drug at a time rather than abstaining from all drugs at once. It is important that patients be positively recognized for such steps.

Access to Clean Needles

Clinicians should issue prescriptions for new needles and syringes to patients who inject drugs.

Clinicians should discuss with patients other options for accessing new needles and syringes, including use of the Expanded Syringe Access Demonstration Program and Syringe Exchange Programs, New York State's two syringe access initiatives.

Clinicians should discuss avoidance of needle/syringe-sharing activity with all injection drug users, regardless of viral load, to prevent HIV and hepatitis B and C virus transmission.

Safe Storage and Disposal of Sharps

Clinicians should ensure that injection drug users receive instructions concerning safe techniques for storage and disposal of sharps.

Refer to Table 5 in the original guideline document for information on safe storage of used sharps.

Safer Injection Techniques

Safe injection techniques should be discussed with injection drug users who are not ready or willing to stop injecting drugs.

Overdose Prevention

Clinicians should counsel substance-using patients about the risk of overdose and how it may be prevented.

Refer to Table 6 in the original guideline document for information on behavioral risk factors for heroin overdose.

Key Point:

Methadone and buprenorphine maintenance have been demonstrated to be effective preventive measures for overdose. Both reduce the use of illicit opioids and maintain a level of tolerance to the effects of opioids, including respiratory depression.

Table 7

Elements of Risk Reduction Counseling to Prevent Overdose

- The risks of using alone.
- The risk of using after a period of abstinence.
- The danger of mixing other depressants with heroin.
- Recognition of the signs of a possible heroin overdose in another user.
- Learning mouth to mouth breathing or cardio-pulmonary resuscitation (CPR).
- Calling 911 to report someone who is unconscious or not breathing. Be prepared for possible police involvement. When the ambulance comes, report exactly what the person took.
- Use of and being prescribed naloxone, an antidote for opioids. Naloxone can precipitate withdrawal symptoms.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of human immunodeficiency virus (HIV)-infected active substance users

POTENTIAL HARMS

Naloxone can precipitate withdrawal symptoms.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening, or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (*HIV clinical practice guidelines*, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience.
- Define target audience (providers, consumers, support service providers).
    - Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.
    - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
- Determine appropriate implementation processes.
    - What steps need to be taken to make these activities happen?
    - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
    - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
    - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
    - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
    - Did the processes and strategies work?
    - Were the guidelines implemented?
    - What could be improved in future endeavors?

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Working with the active user. New York (NY): New York State Department of Health; 2006 Oct. 20 p. [25 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Oct

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies of the guideline: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Common screening tools for identifying substance and alcohol problems. New York (NY): New York State Department of Health. Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 90 Church Street, New York, NY 10007-2919; Telephone: (212) 268-6108

The following is also available:

- Working with the active user. 2006 Oct. Available for Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

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